TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding RX

Respondent Name
Federated Mutual Insurance Company

MFDR Tracking Number
M4-15-4203-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization ..."

Amount in Dispute: $489.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's position as stated on the EOR is that the bill for DOS 12/30/2014 was denied as requiring preauthorization that was not obtained."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 30, 2014	Prescription Medication (Compound Medicine)	$489.96	$489.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.500 defines terms used for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent.
   - 930 – Pre-authorization required, reimbursement denied.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the total reimbursement for the disputed service?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The dispute involves a compound medication consisting of Baclofen, Amantadine HCl, Gabapentin, Amytriptyline HCl, and Bupivacaine HCl. The insurance carrier denied disputed service with claim adjustment reason code 197 – "PERCERTICATION/AUTHORIZATION/NOTIFICATION ABSENT," and 930 – "PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

   28 Texas Administrative Code §134.500 (3) defines inclusion in the closed formulary as:

   > All available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, but excludes:
   > (A) drugs identified with a status of "N" in the current edition of the *Official Disability Guidlines Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;
   > (B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and
   > (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   28 Texas Administrative Code §134.530 (b)(1) states that preauthorization is only required for:

   > (A) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;
   > (B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and
   > (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   The Division finds that Baclofen, Amantadine HCl, Gabapentin, and Amytriptyline HCl are included in the closed formulary and have a status of "Y" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary* effective on the date of service.

   The Division finds that because Bupivacaine HCl is an FDA approved drug, it is included in the closed formulary. 28 Texas Administrative Code §134.530 (d)(2) states, "Prescription and nonprescription drugs included in the division's closed formulary that exceed or are not addressed by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization." Per 28 Texas Administrative Codes §§134.500 (3) and 134.530 (d)(2), although Bupivacaine HCl is not specifically addressed by the ODG, it may be prescribed and dispensed without preauthorization.

   Therefore, because the disputed compound consists only of components included in the closed formulary that do not require preauthorization, the insurance carrier's denial reason is not supported. The disputed services will be reviewed per applicable Division rules and fee guidelines.

2. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

   > (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount…
(2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider

The requestor is seeking reimbursement for a compound of the generic drugs Baclofen, NDC 38779038809; Amantadine HCl, NDC 38779041105; Gabapentin, NDC 38779246109; Amitriptyline HCl, NDC 38779018904; and Bupivacaine HCl, NDC 38779052405. The disputed medication was dispensed on December 30, 2014. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
12/30/14	Baclofen	(35.63000 x 5.4 x 1.25) + $4.00 = $244.50	$184.68	$184.68	$0.00	$184.68
12/30/14	Amantadine HCl	(24.22500 x 3.0 x 1.25) + $4.00 = $94.84	$38.46	$38.46	$0.00	$38.46
12/30/14	Gabapentin	(59.85000 x 3.6 x 1.25) + $4.00 = $273.33	$188.10	$188.10	$0.00	$188.10
12/30/14	Amitriptyline HCl	(18.24000 x 1.8 x 1.25) + $4.00 = $45.04	$30.70	$30.70	$0.00	$30.70
12/30/14	Bupivacaine HCl	(45.60000 x 1.2 x 1.25) + $4.00 = $72.40	$48.02	$48.02	$0.00	$48.02

3. The total reimbursement amount for the disputed service is $489.96. The insurance carrier paid $0.00. An additional reimbursement of $489.96 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $489.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $489.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	September 29, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.